AUTHORITY: Secs 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 USC 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

SOURCE: 75 FR 27138, May 13, 2010, unless otherwise noted.

§ 147.100 Basis and scope.

Part 147 of this subchapter implements the requirements of the Patient Protection and Affordable Care Act that apply to group health plans and health insurance issuers in the Group and Individual markets.

§ 147.102 Fair health insurance premiums.

(a) *In general.* With respect to the premium rate charged by a health insurance issuer in accordance with §156.80 of this subchapter for health insurance coverage offered in the individual or small group market—

(1) The rate may vary with respect to the particular plan or coverage involved only by determining the following:

(i) Whether the plan or coverage covers an individual or family.

(ii) Rating area, as established in accordance with paragraph (b) of this section. For purposes of this paragraph, rating area is determined in the small group market using the group policyholder's principal business address and in the individual market using the primary policyholder's address. For plans (other than qualified health plans offered through the Federally-facilitated Small Business Health Options Program) for which an issuer can demonstrate that it relied in good faith on guidance from an applicable State authority issued before August 28, 2013, that differs from this paragraph (a)(1)(ii), the preceding sentence will not apply until the first plan year beginning on or after January 1, 2015 with respect to coverage in the small group market.

(iii) Age, except that the rate may not vary by more than 3:1 for like individuals of different age who are age 21 and older and that the variation in rate must be actuarially justified for individuals under age 21, consistent with the uniform age rating curve under paragraph (e) of this section. For purposes of identifying the appropriate age adjustment under this paragraph and the age band under paragraph (d) of this section applicable to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal must be used.

(iv) Subject to section 2705 of the Public Health Service Act and its implementing regulations (related to prohibiting discrimination based on health status and programs of health promotion or disease prevention) as applicable, tobacco use, except that such rate may not vary by more than 1.5:1 and may only be applied with respect to individuals who may legally use tobacco under federal and state law. For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.

(2) The rate must not vary with respect to the particular plan or coverage involved by any other factor not described in paragraph (a)(1) of this section.

(b) *Rating area.* (1) A state may establish one or more rating areas within that state, as provided in paragraphs (b)(3) and (b)(4) of this section, for purposes of applying this section and the requirements of title XXVII the Public Health Service Act and title I of the Patient Protection and Affordable Care Act.

(2) If a state does not establish rating areas as provided in paragraphs (b)(3) and (b)(4) of this section or provide information on such rating areas in accordance with §147.103, or CMS determines in accordance with paragraph (b)(5) of this section that a state's rating areas under paragraph (b)(4) of this section are not adequate, the default will be one rating area for each metropolitan statistical area in the state and one rating area comprising all nonmetropolitan statistical areas in the state, as defined by the Office of Management and Budget.

(3) A state's rating areas must be based on the following geographic boundaries: Counties, three-digit zip

codes, or metropolitan statistical areas and non-metropolitan statistical areas, as defined by the Office of Management and Budget, and will be presumed adequate if either of the following conditions are satisfied:

(i) The state established by law, rule, regulation, bulletin, or other executive action uniform rating areas for the entire state as of January 1, 2013.

(ii) The state establishes by law, rule, regulation, bulletin, or other executive action after January 1, 2013 uniform rating areas for the entire state that are no greater in number than the number of metropolitan statistical areas in the state plus one.

(4) Notwithstanding paragraph (b)(3) of this section, a state may propose to CMS for approval a number of rating areas that is greater than the number described in paragraph (b)(3)(ii) of this section, provided such rating areas are based on the geographic boundaries specified in paragraph (b)(3) of this section.

(5) In determining whether the rating areas established by each state under paragraph (b)(4) of this section are adequate, CMS will consider whether the state's rating areas are actuarially justified, are not unfairly discriminatory, reflect significant differences in health care unit costs, lead to stability in rates over time, apply uniformly to all issuers in a market, and are based on the geographic boundaries of counties, three-digit zip codes, or metropolitan statistical areas and non-metropolitan statistical areas.

(c) *Application of variations based on age or tobacco use.* With respect to family coverage under health insurance coverage, the rating variations permitted under paragraphs (a)(1)(iii) and (a)(1)(iv) of this section must be applied based on the portion of the premium attributable to each family member covered under the coverage.

(1) *Per-member rating.* The total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under the age of 21, the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium.

(2) *Family tiers under community rating.* If a state does not permit any rating variation for the factors described in paragraphs (a)(1)(iii) and (a)(1)(iv) of this section, the state may require that premiums for family coverage be determined by using uniform family tiers and the corresponding multipliers established by the state. If a state does not establish uniform family tiers and the corresponding multipliers, the per-member-rating methodology under paragraph (c)(1) of this section will apply in that state.

(3) *Application to small group market.* In the case of the small group market, the total premium charged to the group is determined by summing the premiums of covered participants and beneficiaries in accordance with paragraph (c)(1) or (c)(2) of this section, as applicable. Nothing in this section precludes a state from requiring issuers to offer, or an issuer from voluntarily offering, to a group premiums that are based on average enrollee amounts, provided that the total group premium is the same total amount derived in accordance with paragraph (c)(1) or (c)(2) of this section, as applicable.

(d) *Uniform age bands.* The following uniform age bands apply for rating purposes under paragraph (a)(1)(iii) of this section:

(1) *Child age bands.* A single age band for individuals age 0 through 20.

(2) *Adult age bands.* One-year age bands for individuals age 21 through 63.

(3) *Older adult age bands.* A single age band for individuals age 64 and older.

(e) *Uniform age rating curves.* Each state may establish a uniform age rating curve in the individual or small group market, or both markets, for rating purposes under paragraph (a)(1)(iii) of this section. If a state does not establish a uniform age rating curve or provide information on such age curve in accordance with §147.103, a default uniform age rating curve specified in guidance by the Secretary will apply in that state which takes into account the rating variation permitted for age under state law.

(f) *Special rule for large group market.* If a state permits health insurance issuers that offer coverage in the large group market in the state to offer such coverage through an Exchange starting

in 2017, the provisions of this section applicable to coverage in the small group market apply to all coverage offered in the large group market in the state.

(g) *Applicability date.* The provisions of this section apply for plan years (in the individual market, policy years) beginning on or after January 1, 2014.

(h) *Grandfathered health plans.* This section does not apply to grandfathered health plans in accordance with §147.140.

[78 FR 13436, Feb. 27, 2013, as amended at 78 FR 54133, Aug. 30, 2013]

§147.103 State reporting.

(a) *2014.* If a state has adopted or intends to adopt for the 2014 plan or policy year a standard or requirement described in this paragraph, the state must submit to CMS information about such standard or requirement in a form and manner specified in guidance by the Secretary no later than March 29, 2013. A state standard or requirement is described in this paragraph if it includes any of the following:

(1) A ratio narrower than 3:1 in connection with establishing rates for individuals who are age 21 and older, pursuant to §147.102(a)(1)(iii).

(2) A ratio narrower than 1.5:1 in connection with establishing rates for individuals who use tobacco legally, pursuant to §147.102(a)(1)(iv).

(3) Geographic rating areas, pursuant to §147.102(b).

(4) In states that do not permit rating based on age or tobacco use, uniform family tiers and corresponding multipliers, pursuant to §147.102(c)(2).

(5) A requirement that that issuers in the small group market offer to a group premiums that are based on average enrollee amounts, pursuant to paragraph §147.102(c)(3).

(6) A uniform age rating curve, pursuant to §147.102(e).

(b) *Updates.* If a state adopts a standard or requirement described in paragraph (a) of this section for any plan or policy year beginning after the 2014 plan or policy year (or updates a standard or requirement that applies for the 2014 plan or policy year), the state must submit to CMS information about such standard in a form and manner specified in guidance by the Secretary.

(c) *Applicability date.* The provisions of this section apply on March 29, 2013.

[78 FR 13437, Feb. 27, 2013]

§147.104 Guaranteed availability of coverage.

(a) *Guaranteed availability of coverage in the individual and group market.* Subject to paragraphs (b) through (d) of this section, a health insurance issuer that offers health insurance coverage in the individual or group market in a state must offer to any individual or employer in the state all products that are approved for sale in the applicable market, and must accept any individual or employer that applies for any of those products.

(b) *Enrollment periods.* A health insurance issuer may restrict enrollment in health insurance coverage to open or special enrollment periods.

(1) *Open enrollment periods*—(i) *Group market.* A health insurance issuer in the group market must allow an employer to purchase health insurance coverage for a group health plan at any point during the year. In the case of health insurance coverage offered in the small group market, a health insurance issuer may limit the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each year in the case of a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules as defined in §147.106(b)(3), pursuant to applicable state law and, in the case of a QHP offered in the SHOP, as permitted by §156.285(c) of this subchapter. With respect to coverage in the small group market, and in the large group market if such coverage is offered in a Small Business Health Options Program (SHOP) in a state, coverage must become effective consistent with the dates described in §155.725(h) of this subchapter.

(ii) *Individual market.* A health insurance issuer in the individual market must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods described in §155.410(b) and (e) of this subchapter. Coverage must become